



Irish Journal of Academic Practice

Volume 3 | Issue 1

Article 2

2014-6

How Transformational is Irish Healthcare Education?: Exploring the Role of Intercultural Competence Learning for Practising Health Professionals

Catherine Spencer

Technological University Dublin, catherine.spencer@tudublin.ie

Follow this and additional works at: <https://arrow.tudublin.ie/ijap>

Recommended Citation

Spencer, Catherine (2014) "How Transformational is Irish Healthcare Education?: Exploring the Role of Intercultural Competence Learning for Practising Health Professionals," *Irish Journal of Academic Practice*: Vol. 3: Iss. 1, Article 2.

doi:10.21427/D7P99X

Available at: <https://arrow.tudublin.ie/ijap/vol3/iss1/2>

Creative Commons License



This work is licensed under a [Creative Commons Attribution-NonCommercial-Share Alike 4.0 License](https://creativecommons.org/licenses/by-nc-sa/4.0/).



How transformational is Irish healthcare education? Exploring the role of intercultural competence learning for practising health professionals

Dr Catherine Spencer

Dublin Institute of Technology

Abstract

Research shows that intercultural competence has become increasingly important in the education of health professionals. Policy discourses also construct health professionals in increasingly complex and changing work environments as reflective and culturally competent practitioners. Few studies in the Irish context, however, have examined either the nature of the transformative learning implied or the means by which the shifts towards more culturally competent practice might be pursued and achieved. This case study examines evidence from a course designed to challenge health professionals' understanding of intercultural competence and to guide them in their own examination and implementation of changes and shifts in practice. The study also suggests a number of effective teaching strategies within a framework for transformative learning.

Keywords: Intercultural competence, Professional practice, Reflection, Transformative learning

Introduction

Intercultural competence been widely recognized in recent years as a core clinical competence in Health care. Commitment to intercultural competence and associated communication skills in the curricula for students on wide-ranging programmes in the humanities and social sciences is increasingly evident in the development of new and more recent programmes for students of medicine, nursing, physiotherapy, social work and to some extent the medical sciences (Cleland *et al.*, 2005; Anvik *et al.*, 2008). Alongside professionalism and interpersonal skills, intercultural communicative competence is also increasingly regarded as an essential and wholly ‘teachable’ skill that is linked to improved patient and practitioner satisfaction and better health outcomes for patients (Cleland *et al.*, 2005).

This paper’s exploration of how students reflect on and learn about intercultural competence is premised on an understanding of intercultural competence as a “set of skills and behaviours that enable the practitioner to work effectively within the cultural context of the client”- i.e. the patient and his/her family or community (Waite & Calamaro, 2010, p.74). The acquisition of cultural competence is understood as a developmental and transformative process. Learning, as explored in this paper, is transformative in the sense that it derives from an offering of experiences and tasks that seek to change students so that they in turn can effect transformation in their own environments. Learning is thus understood to “produce knowledge and inculcate skills that emancipate the learner to become an agent of change in super complex and continually transforming environments” (Duncan *et al.*, 2006, p.60).

There is however, very little research as yet in the Irish context that either explores the acquisition and practice of intercultural competence by health professionals or indeed any of the outcomes that such skill development might produce. There has, moreover, been unprecedented transformation of the demographic make-up and organizational structures of the health services and its patient-base. This paper addresses that deficit to an extent and contributes to broader scholarship on transformational learning through qualitative and critical exploration of the experiences of a small group of practising health professionals and their intercultural competence learning, reflections and experiences.

This paper begins with an exploration of intercultural competence through a review of relevant literature and discussion of its specific relevance for healthcare professionals. This is followed by a brief overview of the demographic and professional changes in Irish health care. The aim of the paper is to provide insights into how intercultural competence can be taught and learnt, and the above thus inform the paper's exploration of key constructs in that learning process, such as motivation, relevance and professional identity.

Context of the Study

This case study examines a group of 33 students in final year of a BSc Clinical Measurement Science and my role as tutor of a course in 'Intercultural Communication for Health Professionals'. The majority of the mostly mature, part-time students were also working full-time as health professionals in Irish hospitals. The course combined classroom activity over a number of weekends, and a range of activities and tasks for participants in their own professional settings. My motivation to study the group and their learning stemmed from a strong sense that

students would and could surprise themselves; feedback from previous years had indicated that a degree of 'change' was central. The aim with this research was to document and explore that shift in perspective and practice. Central to deliberations about course design and this case study exploration was a commitment to the development of autonomous thinking and a desire to facilitate a process through which these adult learners, already practicing health professionals, could "learn to effect change in frames of reference [] and make their own interpretations rather than act on the purposes, beliefs, judgments and feelings of other" (Mezirow, 1997, p.5). The commitment was to transform participant thinking rather than prescribe their practices or induce superficial changes to comply with policy directives.

Understanding Intercultural Competence

There is little doubt that intercultural competence has become increasingly recognizable as a desired skill on a wide variety of curricula in higher education. Globalisation, increasing internationalization of education and a more vocal articulation of the moral imperative to improve communication and contact across cultural, ethnic, racial and social boundaries in societies around the world have served to position intercultural competence centre-stage. Many changes in the medical and medical science educational arena regarding explicit communication about culture have been underway for some time in countries such as America, Australia and to some extent Britain (Spector, 2004, p.5). In these countries changing demographics as well as dynamic and sometimes heated public discussion about multiculturalism, racism and inequality have galvanized efforts to address unethical behavior and morality issues among health practitioners in particular. Research findings suggest that the provision of culturally competent

health care services can increase access to healthcare services and reduce racial inequality and health disparities across different social groups (Waite & Calamaro, 2010).

There is an extensive and broad literature on the role of intercultural competence in health care (Spector, 2004; Gropper, 1996; Camhina-Bacote, 2007; Papadopoulos, 2006; Stier, 2004).

Popadopolus (2006, p.8) defines cultural competence in the provision of healthcare as a commitment to the “study and research of cultural diversities and similarities and their underpinning societal and organizational structures [] in order to understand current practices and to contribute to future developments in a culturally-responsive way”. For Popadopoulos, it is a commitment to anti-discriminatory and anti-oppressive practices, about empowering clients (patients) to participate fully in healthcare decisions and in raising professionals’ awareness of how society constructs and perpetuates power and disadvantage. The Popadopoluos *et al.* (2006) cyclical model of cultural competence comprises awareness, knowledge, sensitivity and competence. They argue that throughout our lives, we - and health professionals - develop, refine and use culture-generic competencies, such as understanding how cultural identity mediates health or how social and societal structures may promote or hinder culturally-competent care. It is from such a base that health professionals can acquire and develop more culture-specific competencies (Popadopoluos, 2006, p.21). Cultural competence in health care implies that understanding, knowledge, curiosity and awareness be applied in interactions with fellow professionals and patients. As a skill it operates alongside (although not always without tension) other clinical skills and obligations, such as duties of care to patients and to the ethical and professional standards by which healthcare professionals are bound.

When understood as a developmental process, the acquisition of intercultural competence can effect change and transformation along affective, cognitive and behavioural axes. Bennet (1993; p.21), for example, underlines the need to prioritise the developmental aspects of intercultural learning by adopting an appropriate range of approaches and training methods. Central to such a dynamic and developmental view of intercultural competence is its capacity to induce adaptation and shift perspectives. Learning is thus transformative.

Drawing on Mezirow's (1997) work on transformative learning, the acquisition of cultural competence also implies changes in the roles and self-concepts that learners experience. As participants become more critically aware of their own personal, historical and cultural contexts, their assumptions and frames of reference change. These are what Mezirow termed "perspective transformations" which "empower participants to respond to circumstances with a wider repertoire of possible actions" (Fleischer, 2006, p.148). Attitudes and beliefs formed earlier in life can constrain adult conceptualisations, the integration of new meaning and the development of more discriminating schemata unless accompanied by a "transformation of meaning perspectives" (Fleischer, 2006, p.148). Such transformation requires critical reflection on one's experiences and actions and a "surfacing" of the premises underlying one's understandings and actions, "for reflection, modification or expansion" (Fleischer, 2006, p.148). This is evident in the data provided by this case study - both in participants' documented reflections and in their modifications to practices in their own professional environments.

In an extensive literature on how to 'acquire' intercultural competence, there is some convergence on the need for adequate reflection, teacher/tutor sensitivity and the relevance of

both cultural (self) identity and the cultural frameworks through which we interpret behavior and expectations. There is a concomitant focus on experiential learning and on issues around motivation and commitment in much of the literature (Paige, 1993; Stier, 2004). As transformative process, the development of intercultural competence implies not so much a rejection of ideas that have become “unworthy of consideration” but rather, a shift towards frames of reference for learners that are “inclusive, discriminating, self-reflective and integrative of experience” (Mezirow, 1997, p.5).

Healthcare Provision - Ireland in Transition

Recent demographic changes in Ireland have been dramatic and substantial. The 2006 Census of Population was the first in Ireland in which data on ethnicity and cultural background were collated. In that year, Irish nationals accounted for 86.8% of the resident population; 2.7% claimed UK nationality, 3.9% claimed other EU nationality, 3.5% claimed ‘other’ nationality/ethnicity and 1.1% were classified as ‘not stated’ (Central Statistics Office, Census of Population, 2006). The 2007 Quarterly National Household Survey on Health Status and Health Service Utilisation provides further useful information on non-Irish nationals’ interaction with health services in Ireland (all statistics relate to adults and to services attended on more than one occasion); 6% attended Accident & Emergency services, 9% attended out-patient services, 4% attended day-patient services, 5% attended in-patient services and 16% attended ‘any hospital’ for any of the four listed services (CSO, QNHS, 2007, p.14). Increasing diversity in terms of ethnicity, nationality and religious affiliation are thus evident in the Irish context and build on the diversity of religious groups and ethnic communities that were present before this most recent wave of population growth; in the mid-1980’s Ireland’s population was approximately 4.5

million, today it is closer to 5.5 million. The Health Services Executive Intercultural Guide (HSE, 2009, p.5) was developed in response to an “expressed need by healthcare staff across a range of cultural backgrounds for knowledge, skills and awareness in delivering care to people from backgrounds other than their own” and highlights also the diversity of healthcare staff and the needs of minority ethnic staff who are often in direct healthcare provision roles. HR data pertaining to three administrative areas in the HSE and to St James hospital, Dublin, for example, suggest that approx. 33% of medical/dental staff, 15% of midwifery and nursing staff and 9% of health and social care professionals are from minority ethnic communities.

A range of policy documents from the Irish Health Services Executive and some locally-generated policy guides and codes of practice for staff, induction materials for new staff etc. all articulate the *need* for intercultural awareness and skills.

The first requirement is that we in the health service acknowledge diversity and the differences in behaviours and in the less obvious areas of values and beliefs that this often implies [] Awareness and sensitivity training for staff is a key requirement for adapting to a culturally diverse patient population [] Workforce cultural diversity affords us the opportunity to learn from the working practices and perspectives of others.....

Cultural diversity in the Irish Health Care Sector: Towards the development of policy and practice guidelines for organizations in the health sector (2002, p.5 & p.10).

However, despite such rhetoric there is little empirical research that documents the ‘practice’ of raising awareness, or of the nature of intercultural teaching and learning in Irish health care.

There is little or no documentary data either on experiences or outcomes. Rhodes & Scheeres (2004, p.176) argue, for example, that the emergence in recent years of postmodern learning discourses that valorize participation, empowerment, flexibility and diversity has not necessarily signaled wholesale change in the ‘practices’ in organizations but has, in fact, created situations of

discursive conflict where ‘workers’ – in a wide variety of roles - take up a wide range of positions with respect to policy. Fanghanel (2007, p.189) cites Trowler (1998) in elaborating how responses to policy (in Higher Education) can extend from outright rejection to full acceptance with a variety of subtly-differentiated positions in between. Thus, for example, *adaptation* rather than adoption, and ‘creative’ but sustainable subversion constitute the possible responses and modes of ‘policy reconstruction’ by health professionals in new cultural work environments increasingly dominated by discourses that promise empowerment, capacity for renewal, more satisfying work and greater respect for diversity (Rhodes & Scheeres, 2004). Policy discourses, even when contested, might also have the power to function as “regimes of truth” (Ball, 1994, p.23) and so prescribe or limit the possibilities for thinking or acting *otherwise*. Although discursive constraints cannot be exhaustively explored in the present paper, their relevance is nonetheless significant. The paper’s exploration of empirical practice data might also point to useful routes of enquiry in research on policy reconstruction and learning discourses in Irish health care.

Motivation, Relevance and Professional Context

The question of motivation is central for educational researchers and integral to exploration of student learning, although Kember *et al.* (2008, p.20) suggest that the advent of mass higher education and a deficit in empirical research in higher education may impede comprehensive discussion; most studies they argue, are either overly theoretical or limited to second-level contexts).

One well-established and relatively uncontested aspect of the broader discussion is recognition of need to establish relevance and to illuminate the relationship between theory and practice (Kember *et al.*, 2008, p.2). It was important from the outset to make that relationship explicit to students in their initial assessment of their IC experiences and through their provision of ‘critical incidents’, for example. It underpinned course design and proved itself a dominant concern in student reflections on practices and learning. Relevance relates to both goals and content. Hodgson’s (1984) exposition of the extrinsic, intrinsic and vicarious experiences of relevance suggest students can and do react in different ways to material and context. Intrinsic motivation results when students think about concepts presented in terms of their own experiences and knowledge frameworks. This type of motivation was integral to consideration of design and learning outcomes.¹ Keller’s (1983) instructional design theory also explicitly addresses motivation and relevance and does so in terms of learners’ perceptions of the satisfaction of their needs in relation to the instruction they receive (cited in Kember *et al.*, 2008, p.21). For Keller & Suzuki (2004, p.231), relevance means that learners “perceive the instructional requirements to be consistent with their goals, compatible with their learning styles and connected with their past experiences”.

Relevance is clearly a condition for ‘Situated Learning’ (McLellan, 1995) and the broader context in which the to-be-learned concepts normally occur (and thus sometimes the antithesis of classroom learning). Case-based learning and problem-based learning (PBL) also derive from consideration of relevance, and both generally seek also to generate generic capabilities or

¹ Extrinsic experiences of relevance occur when students react to concepts predominantly in terms of tasks to be completed; vicarious experiences of relevance are those in which students react to concepts because they perceive lecturer’s interest or enthusiasm or identify with personal perspectives articulated by lecturer.

advance multidisciplinary perspectives (Kember *et al.*, 2008, p.21). Although Kember *et al.* (2008) acknowledge the work on relevance as a factor in motivation, they argue that further empirical evidence is required to advance general discussion and research on curriculum design and student learning. This research seeks to advance that discussion through its qualitative focus on student reflections on professional experience, and both the relevance and learning of Intercultural Competence.

Broadly speaking, motivation, from an educational perspective can be usefully understood as a *‘multifaceted construct that encompasses a variety of meaningful connotations pertaining to learning and educational development’* (Sobral, 2004, p.38). Pintrich (cited in Sobral, 2004) identifies three main categories of concepts relevant to motivation that are pertinent in the present study: personal beliefs in the students’ own ability to undertake activities and tasks; reasons for engagement with material and affective reactions to learning activities; and content. The former and latter, in particular, were strikingly evident in my analysis of the data generated by the research. Student reflections on extrinsic motivation - linked to outcomes - and intrinsic or autonomous motivation - linked to enjoyment and interest – are both evident from analysis of the data and highlight what Sobral (2004, p.38) refers to as the “context of interlocking rewards and relationships, incentives and barriers as they go through their learning experiences”. What is particularly relevant for this paper is the question of “dissonant influences” (Mann cited in Sobral, 2004, p.21) as factors that might explain an apparent lack of interest and surface-learning or purely instrumentalist and extrinsic learning modes. The discussion in this paper of research data elaborates on such factors and although the research was not designed to explore motivation alone, its importance for relevance and student learning is established.

Scholars who make claims about the benefits of PBL for students frequently cite the positive impact on motivation and student learning (Van Berkel & Schmidt, 2000). As a constructivist approach to professional education that emphasizes the use of real-life problems in instruction, it actively encourages students to formulate goals and self-direct. As a mode of learning, however, it does not have a monopoly on the desired outcomes that are also evident or at least explicitly sought in many non-PBL programmes at tertiary level. In the present study, for example, many of the features cited by Van Berkel & Schmidt (2000, p.232) are central: the real-life relevance of intercultural competence in professional contexts; learning is contextually valid; learning is cooperative; problem-solving is enhanced; students are motivated. Although neither claiming an exclusive PBL-approach nor indeed denigrating the specifics of PBL, it is suggested here that the above constitute overarching aims and goals in the course under exploration and so constituted aspects for consideration in the thematic analysis of data, particularly the link between motivation and context-relevant material for student learning.

Professional Context

As professionals operating in specific institutional, organizational and cultural environments the students in the present study are, in their professional practices, called upon to act, think and perform in a multitude of different ways and to satisfy a wide variety of roles. Ongoing modernisation in health provision services and efforts to improve client care have resulted in increasingly complex work environments and multi-professional team work (Adams *et al.*, 2006, p.56). Traditional professional demarcations are thus being challenged and contested and professionals are called upon to demonstrate greater flexibility and collaborative skills. Moreover, like other professional groups within the health services - for example, doctors,

nurses, social workers etc. - these professionals (and students) are constructed in increasingly pervasive discourses as reflective, critical and lifelong learners (Rutter, 2006, p.282). Adams (2002, p.86) highlights how demanding all of this is for students who are expected to acquire knowledge that might only be useful in particular instances and indeed knowledge that often 'conflicts' with existing knowledge and practice. They face, moreover, persistent obligation and requirements to review 'taken-for-granted' assumptions or practices. For professionals and for the students in the present study, learning is thus linked to how they subjectively self-conceptualise with regard to their work roles and whether and how they engage in re-conceptualisation. Learning is also to some degree a question of student creativity "requiring high levels of confidence with all types of knowledge and information" (Rutter, 2006, p.282). Hence the concern in the present study with exploration of the degree to which transformative elements of learning can be discerned.

'Active' learning as a "process of making students the centre of their learning" (Warren, 1997, p.16) requires a degree of processing by students in which concepts learned are positioned within a wider experiential framework or context. The notion of context, however, is complex and not always well-substantiated in much literature on medical and medical science education (Koens *et al.*, 2005, p.1243). In the present study an extended view of context is adopted. Context is not merely understood as the setting in which material is learned or encountered (namely the classroom or indeed the clinical and professional environment upon which students report and reflect). The extended concept of context adopted for the present study implies that to-be-learned material is considered for its problem-solving applications as well as for future applications of knowledge and reflection on learners' current knowledge. Koens *et al.*'s (2005) elaboration of a

3-dimensional ‘context’ in medical education - physical, semantic and commitment - served as a useful starting point for this study’s exploration of student learning and its focus on motivation, relevance and professional practice. The transition and transfer of knowledge from classroom to clinical setting (as is the case for this study’s exploration of health professionals’ learning about intercultural competence) often results in a ‘shock of practice’ (Boshuizen cited in Koens *et al.*, 2005, p.1243) that engenders cognitive responses in terms of skills deficits as well as affective responses. The notion that context-dependency or clinical relevance would underpin education in health disciplines is undisputed (Koens, 2005). The question in this current study was thus one of how best to ‘extend’ the classroom environment to incorporate the clinical and professional context and to engage students in that elaboration.

The provision and collective sharing and reflection by students of insights from self-selected ‘critical incidents’ (through an online forum and in classroom presentation) in the present study, for example, demonstrates both that ‘active’ commitment and a consideration of context that went beyond individual participant experiences.

Reflection and Active Learning

Reflection, as a tool of motivation and as means by which to establish relevance in the classroom setting, allows educators to narrow the theory-practice gap and functions as a resource from which further learning can proceed (Bulpitt & Martin, 2005). Students engaging in effective reflection are enabled in development of their own understanding and knowledge for both their learning and in their professional practices. There is a long history of scholarly work on the value of student reflection and more recently, reflection has featured prominently as an area of interest

to those concerned with professional education. Bulpitt & Martin, for example, cite Mezirow (1990) and Schon (1987) and their arguments in favour of reflection as a “means by which practitioners can challenge underlying assumptions in order to develop perspective transformation” (2005, p.207). Transformation is achievable if learning conditions are facilitative, if value conflicts are handled effectively and if the operation of reflection is coached and developed within students. Such conditions and outcomes are clearly desirable and there is little to dispute their validity or value for learning and in particular for professional education. However, Boud & Walker (1993) suggest that ‘internal barriers’ to reflection, such as those associated with self-awareness, preparation and intent, and ‘external barriers’ associated with support systems, inadequate preparation and scope for practice or application can adversely affect students’ ability to reflect and indeed their capacity to derive value and meaning from such reflection. The optimal conditions for effective reflection and reflection-derived learning are thus time, scope, support and a degree of collaboration and congruence between educators, students and indeed the professional contexts in which students operate or will operate.

Reflection is also widely recognized as an essential part of professional practice in the health professions at both pre- and post-qualifying levels (Ilthe, 2003). Practice in such professions is characterized by a proof of expertise based on outcomes rather than on underpinning knowledge; there is less reliance on factual detail and more on interpretation and understanding of complex situations (Moon, 2000, p.55). Evidence for such phenomena is apparent from the case study as is a concern with the gap between theory and practice (Bulpitt & Martin (2005). There are several mechanisms by which reflection is facilitated as well as experienced and awarded meaning in the case study. Students provided and shared written reflective pieces on self-selected

‘critical incidents’ and on ‘intercultural interviews’ that they had carried out in their workplaces. Students’ own knowledge, practices and experiences thus constituted starting points for discussion and ‘situated’ learning resources. By facilitating a reflective process that derived initially from ‘known’ variables and went on to incorporate the newly acquired concepts and skills, it was important to integrate it as much as possible and to facilitate a learning that would reflect the diverse experiences, environments and different levels of commitment and engagement in the participants. Reflection thus served to customize learning in the sense that it served a range of values and meanings that were not uniform for all participants.

The notion of ‘active’ learning has gained prominence in recent years. In broad terms ‘active’ can be understood to apply to learning that is student-centred and where students engage in discovery-oriented activities and tasks, where teaching methods and modes are varied and where students are consistently required to explore, reflect and interpret (Cherney, 2008, p.152). Active learning suggests that “information is processed [and encoded] to a ‘deep’ level” (Cherney, 2008, p.153) and thus not simply processed through shallow and superficial analysis of structural features. Deep and active learning can thus contribute to better recall, improved retention and more effective application of knowledge and concepts learned (Cherney, 2008, p.155). Smith & Kosselyn (2007) argue that the ‘generation effect’, namely the processing of information based on learners’ own encoding, structuring and positioning of information is far more effective for student learning than the ‘spacing effect’ which is when information is heard from someone else and encoded across multiple trials. Active learning then is also a matter of encoding, attending to and processing information so that it can be drawn upon or retrieved, remembered and applied. Retrieval is cue-dependent, that is stimulated by hints and clues and context. Active learning

enhances student retention of concepts, particularly when students are ‘authors of their own learning’ (Cherney, 2008, p.155). The current research is not concerned with neurological processing of stimuli, nor with degrees of retention or recall. However, the exploration of student learning is concerned with student reflections on ‘active’ learning tasks, on context and on relevance and with the degree to which students both engage with the concepts concerned and process them in relation to their own (professional) experiences.

The ‘intercultural interview’ task which required participants to interview a colleague and to explore issues and attitudes surrounding cultural practices, acculturation, and culturally-motivated professional practices clearly demonstrates the commitment to ‘active’ learning in the case study. Obviously student-centred, the task also required participants to act independently and to self-direct in their own work environments. Reflecting on the task and reporting to the group on the interview catered for further processing by students and advances the ‘generation effect’ (Smith & Kosselyn, 2007).

Case Study: Research Design

The research sought to investigate empirically the ‘practice’ of teaching and learning intercultural competence through examination of the effectiveness of assigned learning tasks. As a case study it provides examples of “real people in real situations, enabling readers to understand ideas more clearly than [] abstract theories or principles” (Cohen *et al.*, 2011, p.288). It is a study of how complex knowledge - intercultural competence - is acquired in a concrete setting - health professionals engaging in continuing and further education. The case study provides much needed empirical data about intercultural competence learning in the Irish

context. The aim was to provide empirical evidence about the nature of health professionals' 'acquisition' of intercultural competence and to establish the centrality of relevance, motivation and professional identity as constituents in the learning paradigm/framework. As well as close observation and recording of student interactions and comments in discussions and in classroom activities, student reflections and outputs were collected and analysed to identify themes and patterns and to deepen understanding of how learning happens. The data was thus subjected to closer examination and coding included students' questionnaires, student reports, reflections on critical incidents, intercultural interviews, digitally audio-recorded focus group discussions and group presentations. This qualitative analysis using ethnographic-style and discourse-analytical techniques produced findings that were derived from a content/thematic analysis of student-produced materials.

Collating and presenting data for the case study has served "holistic" purposes in Verschuren's terms (Verschuren in Cohen *et al.*, 2011, p.289) in the sense that "relevant areas of interest", namely learning about intercultural competence, can be examined. The case study both describes and analyses, and strives for nuanced, embedded and 'thick' description (Geertz, 1973). Located in the practice of teaching and learning about intercultural competence, this case study seeks to be a "step to action", a data source for teachers, students, institutions and even policy makers - providing perhaps a wider variety of audiences with insights and frameworks for interpretation and action (Adelman *et al.*, in Cohen *et al.*, 2011, p.289).

Research Participants

The case study presented and discussed below relates to a group of students in their final year of a BSc Clinical Measurement Science and their participation in a course entitled 'Intercultural Communication for Health Professionals'. The group consisted of 33 participants, most of whom were mature, part-time students who were also working full-time as health professionals in Irish hospitals around the country. For approximately one third of the students, this was the fourth year of a four-year part-time degree programme. For the remainder, this was the second year of a two-year conversion programme that allowed them upgrade previously acquired diplomas to degrees. The course in 'Intercultural Competence' was delivered over four weekends and 30 students attended fully all four sessions. In designing the course it was important to be mindful of a number of issues:

- The diversity of the student group and significant variance in terms of age, professional experience, educational background, nationality and hospital/institutional experience.
- The perceived commitment to and shift towards 'diversity' awareness' in public rhetoric and policy and the reality of 'diversity awareness' in practice.
- The 'non-core' nature of this course (all other courses taken by students were in the areas of scientific knowledge and measurement of physiological signals, namely anatomy and physiology, measurement and technology, enabling students upon graduation to work in multidisciplinary teams in the areas of cardiology, vascular physiology, respiratory physiology and neurophysiology).
- The predominantly part-time status of students who had busy professional lives (as well as family and social commitments) in complex and changing work environments.

All students consented to their work being considered as part of the current research.

Course Outline

The overarching aims for the course were to deepen student understanding and knowledge of intercultural competence through exploration of students' own understandings or applications and by introducing them to relevant scholarly material. The objective was to enable them to 'position' intercultural competence alongside their other professional commitments and to guide them towards the development of strategies for more culturally competent behaviours or actions. The tasks and activities adopted for students were designed in such a way as to realize those goals and to engage students as active learners in critical reflection "in order to develop perspective transformation" (Bulpitt & Martin, 2005, p.207) and to enable learners become "agents of change" in their 'complex and continually transforming environments" (Duncan *et al.*, 2006, p.60).

Data Collection

At the outset, students were asked to complete a 40-item questionnaire in which they assessed and rated their prior experiences of intercultural communication, prior learning or training, affective attitudes towards intercultural communication, institutional commitments to Intercultural communication etc. They subsequently distributed the questionnaires in their own workplaces to generate discussion on-site and to give them insights into colleagues' perspectives. All course materials (literature resources and workshop material about Intercultural knowledge & understanding, online activities) were provided in hard copy in class and in advance in an online environment (WebCourses, DIT). Students engaged in both face-to-face classroom discussion and in online discussion for their preparation and completion of 'critical incidents' and the 'intercultural interview'. The 'critical incident' is a well-known and much-reviewed tool

of cross-cultural training (Cushner, 1989; Wight, 1995) aimed at increasing learners' sensitivities to a wide range of experiences, feelings and thoughts that are typically encountered during cross-cultural interactions. The students in the case study were introduced to this, but their own 'critical incidents' were continuously revised in order to compile an annotated learning resource that provided them with greater professional context and hence relevance. The students were also required to carry out an 'Intercultural interview' in which they engaged in experiential learning with a colleague/patient from a cultural background different from their own; the intention of this was to explore the issues surrounding cultural attitudes to health, sickness, healthcare and to communication and behavioural norms and expectations in the professional environments they co-inhabit. Students were required to submit a number of written assignments – reflections and reports on tasks, workplace critiques, recommendations for workplace change and to engage in group presentations and focus-group discussions at the end of the course.

Findings and Discussion

The data was collated and organized in a way that best served the purposes of the research, namely to explore the nature of participants' learning process and in a manner that would describe and provide detail, suggest interpretation, and analysis, explain causalities and discover links, commonalities and differences (Cohen *et al.*, 2011, p.539). It was important to be mindful of the richness and complexity of the data emanating from a "double hermeneutic" process (Giddens in Cohen *et al.*, 2011, p.540) - the interpretation of data from participants who have in turn interpreted their experiences and situated knowledge. Data was thus organized and selected to reflect key questions in the research about the role of motivation, relevance, and a sense of professional identity. Themes and issues were thus to some extent pre-determined. The

interpretive and reflexive character of data analysis also ensured, however, that emergent themes, concerns or insights were also catered for. Through content analysis and coding or ‘tagging’ of the data to identify the main thematic threads, the main findings can be summarized.

Motivation as the “meaningful connotations pertaining to learning and educational development” (Sobral, 2004, p.38) featured prominently in students’ products. For many of them, the course presented a challenge in terms of the type of material and task they were presented with and in terms of the reflection and self-examination they engaged in. Several articulated an initial discomfort with the mode of learning, comfortable and used as they were to a more direct provision of material and a less intensive examination of existing knowledge and how to re-construct it. ‘Extrinsic motivation’ thus featured more strongly in their early assessment of expectations; purely instrumentalist learning modes and a degree of resistance also featured in initial sessions as well students’ own accounts of their learning. Illustrative statements included the following; *‘I really don’t get why I’m here’*; *‘Can you not just give us a list of how we should behave with different cultures’*; *‘I’m really struggling with all of this and it’s just not what we normally do’*. Early affective responses from students (articulated in students’ own post-course reflections) show some evidence of apathy, indifference and even hostility (articulated by two students in unambiguous body language). As Sobral suggests, such “dissonant influences” (2004, p.21) and others such as time pressures and work commitments impact on motivation and may adversely affect learning.

Initial questionnaires completed by students revealed in the majority of them a mismatch between student assessment of existing knowledge and its application in practice. Most students expressed an interest in the material to be addressed, namely an interest and curiosity about

cross-cultural interactions, most had lived or worked abroad at some stage and had had cross-cultural experience. However, very few cited this 'knowledge' or 'experience' in allowing them define themselves as culturally competent. Nor did they rate their extensive experiences in clinical settings with other diversities - in terms of age, gender and status - as evidence of their own awareness or as a base from which to develop further 'cultural' competence. Analysis of these questionnaires revealed also a lack of formal training, despite much policy rhetoric. Only five had engaged in any on-site cross-cultural training. In summary, the questionnaires revealed a striking lack of recognition by students of the value of their extensive experience and a very latent awareness of intercultural competence.

The illumination of the link between theory and practice, namely the establishment of relevance is a necessary condition for active learning and strongly linked to motivation. Through their own compilation of critical incidents and their subsequent re-constitution as a learning resource, students were required to reflect on and review their own practices and experiences in their clinical work environments. Only four students approached this task from a more instrumentalist perspective, producing basic scenarios with obvious solutions. The remainder, however, approached the task with more enthusiasm and produced complex scenarios and incidents from their clinical settings that generated heated debate in the classroom. Analysis of student products suggests that this activity generated significant intrinsic or autonomous motivation - namely in terms of enjoyment and interest. Students also cited their 'pleasure and relief' in hearing colleagues' experiences. For some, this activity, the attendant group discussion and review of incidents constituted a turning point in their motivation and affective responses; it signaled recognition of the relevance and extent of their own knowledge and experience, their ability to

determine where they might go with course material and their ability to position themselves along a learning curve. Several students claimed, for example, that the interactional and communicative aspect of their professional roles was the most demanding and yet least prepared or trained. This activity had allowed them engage more comprehensively with that aspect of their professional practices and ‘relevance’ of the material became more immediate; although specifically attuned to cross-cultural interaction, they recognized the potential for all their clinical interactions to be transformed.

An analysis of reflections on students learning from the ‘critical incident’ activity also revealed its ‘affirmative’ potential, providing students with a sense of confidence in their own ability to respond in a variety of ways. For approximately one third of the students, it was this interactional and communicative aspect of their jobs with which they identified themselves most clearly as professionals. Students recalled ‘incidents’ with patients in which they had better ‘learnt’ their roles – their professional identities had been strengthened through these interactions. It is clear that such critical experiences where procedures and rules experienced by students or novice professionals can trigger the construction of a professional identity. Professional socialization and identity formation is thus about individuals ‘developing a sense of what it actually means to be a professional (Adams *et al.*, 2006, p.57). Analysis of the data, and in particular of students’ assessment of the ‘critical incident’ activity, suggested a certain satisfaction in students’ recognition and acknowledgement of their ‘cognitive flexibility’ (Adams *et al.*, 2006) as professionals. It thus constituted a deeper awareness that in any given situation there are options and alternatives available, a willingness to be flexible and adapt to the situation and a self-efficacy or belief that one has the ability to be flexible. The scope for demonstration of

professional identity occasioned by the critical incident activity also allowed students demonstrate their ability to “structure knowledge and respond to changing situational demands” (Adams *et al.*, 2006, p.58). The relevance for students’ professional lives and selves thus constituted a significant factor in their motivation and how they felt about what and how they were learning.

A change in attitude, approach or awareness in cross-cultural interactions - either self or outwardly directed - constituted one of the educational outcomes or aims of this course in intercultural competence. Given the short time frame for work with students and the complexity of measuring such psychological change, however, the analysis sought to explore impact rather than an abstract measure of the achievement of aims. The achievement of learning outcomes is, of course, the preserve of the learner. In terms of impact of interest was not only in the actual knowledge or skills acquired, but in evidence of relevant or appropriate changes in practice (Moon, 2004). Analysis of student reflections and products suggested a shift in attitude as a result of the ‘Intercultural interview’ activity, for example. At least half of the students expressed an initial degree of anxiety, fear, apprehension, discomfort or lack of enthusiasm towards the activity. For more than two thirds, however, there was a high degree of satisfaction on its successful completion. Amongst those who were initially confident about the task and their choice of interviewee, many nevertheless expressed ‘surprise’, ‘a need to ask more’, and a desire to ‘push the boundaries a bit’, ‘not play it too safe’. A small number expressed this shift in terms of ‘delight’ ‘excitement’ and ‘a great buzz’. The analysis of student products in relation to these interviews thus suggests very perceptible shifts - at cognitive, behavioural and affective levels - and a curiosity and commitment to ask more questions from colleagues and patients about

cultural practices and behaviours. The analysis thus reveals evidence of students' reflective learning, namely in the "mental processing they applied to relatively complicated, sometimes ill-structured (or ill-informed) ideas for which there is not necessarily an obvious solution" (Moon, 2004, p.8) as well as a "mulling over of ideas that have already been learned, the re-organizing of them – and consideration of how, for example, what has been learnt will fit into the patterns of the workplace to improve practice" (Moon, 2004, p.8).

A combination of course activities, online, on-site and both group and individual activities outside of class time sought to engage students in a more sustained reflective process and thereby increase the potential for impact and changes to their practices. Several students reported on actual actions and activities they had initiated as a result of their reflection; others reported on a range of intended actions and commitments such as:

- requesting further team training or meetings to address issues at work;
- making more conscious effort to engage at more levels with colleagues from different cultural backgrounds;
- undertaking to enquire and learn more from patients in the limited opportunities for interaction with them;
- seeking to influence management awareness of issues and requirements in intercultural matters.

The analysis thus suggests evidence of the 'transformative' quality of student learning, revealing a degree of change in the students themselves that are explicitly articulated in normative and prescriptive statements of intent. Sometimes change is recognizable less as a consciously-chosen

behavior, but there nonetheless as an ‘unexpected’ or indirect outcome of student learning. Despite professional constraints and concerns relating to time, patient throughputs and a pressure to ‘treat them all the same’, the analysis significantly highlights a reconstruction of students/professionals as authors, instigators and as ‘agents of change’ (Duncan *et al.*, 2006, p.60) in their organizations and work environments.

Conclusion

A number of limitations need to be noted here. The research was conducted with a relatively small number of students in class-based and off-site activities, and as such does not provide sufficient evidence for broadly generalisable recommendations. Students too may have responded and participated in a manner they felt were desirable in a course such as this. However, such limitations can be mitigated when student are made aware from the outset - as they were in the present study - of the sensitivity of transformative learning experiences and that challenging basic assumptions “can be fraught with resistance even when the outcomes may be a desired expansion of consciousness” (Ettling, 2006, p.59). Instructors’ mindfulness with regard to student needs and intended educational goals is, of course, a constant.

The present study nevertheless illustrates the potential and efficacy of active learning tasks in achieving transformation in student understanding and application of intercultural competence. Underpinning the study is recognition of the need to envisage professional practice in its entirety and complexity, and to view student learning as a vehicle for conceptual change. The establishment of relevance as a central concern in efforts to motivate and engage students, particularly in terms of their intrinsic motivation, is highlighted; specifically it is illustrated in

data findings which suggest a significant degree of perspective-shifting or transformation along cognitive, behavioural and affective axes. Analysis of student products reveals, for example, the importance of wider experiential frameworks for student learning, the capacity of learning to sustain and develop professional identity and the impact of effective learning on student awareness of autonomy, cognitive flexibility and the ability to effect change in their professional lives. As the pace and nature of change in today's diverse health-care environments increases, and as discursive construction of today's health-care professionals intensifies, the present study's exploration of empirical practice data contributes to scholarly enquiry into effective teaching, learning and good practice in a recognizably under-researched Irish context.

Further research is recommended to gather additional empirical data to broaden and deepen understanding of the nature of *how* intercultural competence can be taught and learnt, and to develop the repertoire of tools and means by which instructors might achieve desired transformations and change. Research into how practicing professionals respond to and reconstruct the learning and professionalizing discourses that permeate their working environments can only enhance this, as it would enable both educators and policy makers to consider more comprehensively the potential impacts and outcomes of their articulated aims and actions.

References

- Adams, K., Hean, S., Sturgis, P., & Clark, J.A. (2006). Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care*, 5(2), 55-68.
- Adams, R. (2002). Developing critical practice in social work. In R. Adams, L Dominelli, & M Payne (Eds.), *Critical Practice in social work* (pp.83-95). Basingstoke: Palgrave.
- Adelman, C., Kemmis, S., & Jenkins, D. (1980). Rethinking case study: notes from the Second Cambridge Conference. In H Simons (Ed.), *Towards a Science of the Singular* (pp.45-61). Norwich, UK: University of East Anglia.
- Anvik, T., & Grimstad, H., Baerheim, A., Fasmer, O.B., Gude, T., Hjortdahl, P., Holen, A., Risberg, T., & Vaglum, P. (2008). Medical students' cognitive and affective attitudes towards learning and using communication skills - a nationwide cross-sectional study. *Medical Teacher*, 30, 272-279.
- Boud, D., & Walker, D. (1993). Barriers to reflection on experience. In D. Boud, R. Cohen, & D. Walker (Eds.), *Using experience for Learning* (pp.73-86). Buckingham: Open University Press.
- Bulpitt, H., & Martin, P.J. (2005). Learning about reflection from the student. *Active Learning in Higher Education*, 6(3), 207-217.
- Campinha-Bacote, J. (2007). *The Process of Cultural Competence in the Delivery of Healthcare Services: The Journey Continues* (5th Edition). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Cappell, J., Veenstra, G., & Dean, E. (2007). Cultural Competence in Healthcare: Critical analysis of the construct, its assessment and implications. *The Journal of Theory Construction and Testing*, 1, 30-37.
- Cherney, I. (2008). The effects of active learning on students' memories for course content. *Active Learning in Higher Education*, 2, 152-171.
- Cleland, J., Foster, K., & Moffat, M. (2005). Undergraduate students' attitudes to communication skills learning differ depending on year of study and gender. *Medical Teacher*, 27(3), 246-262.
- Cohen, L., Manion, L., & Morrison, K. (2011). *Research Methods in Education*. 7th Edition. London: Routledge.
- Cushner, K. (1989). Assessing the impact of a culture-general assimilator. *International Journal of Intercultural Relations*, 13, 125-146.

- Duncan, M., Alperstein, M., Mayers, P., Olckers, L., & Gibbs, T. (2006). Not just another multi-professional course Part 1 Rationale for a transformative curriculum. *Medical Teacher*, 48(1), 9-63.
- Ettling, D. (2006). Ethical Demands of Transformative Learning. In E. Tayler (Ed.), *Teaching for Change. New Directions for Adult & Continuing Education* (pp.59-68). San Francisco: Jossey-Bass.
- Fleischer, B.J. (2006). Mezirow's Theory of Transformative Learning and Lonergan's Method in Theology: Resources for Adult Theological Education. *The Journal of Adult Theological Education*, 3(2), 147-162.
- Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.
- Gropper, R. (1996). *Culture and the Clinical encounter. An Intercultural Sensitizer for the Health Professions*. London: Nicholas Brealey Press/ Intercultural Press Inc.
- Hodgson, V. (1984). Learning from Lectures. In F. Marton, D. Hounsell & N. Entwistle (Eds.), *The Experience of Learning* (pp.159-171). Edinburgh: Scottish Academic Press.
- Jones, A. (2007). Putting practice into teaching: an exploratory study of nursing undergraduates' interpersonal skills and the effects of using empirical data as a teaching and learning resource. *Journal of Clinical Nursing*, 6, 2297-2307.
- Keller, J.M., & Suzuki, K. (2004). Learner motivation and e-learning design: a multinationally validated process. *Journal of Educational Media*, 29(3), 229-239.
- Keller, J.M. (1983). Motivational design of instruction. In C.M. Reigeluth (Ed.), *Instructional design theories and models: an overview of their current status* (pp.384-434). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Kember, D., Amber, H., & Celina Hong, H. (2008). The importance of establishing relevance in motivating student learning. *Active Learning in Higher Education*, (3), 249-263.
- Landis, D., Bennet, J., & Bennet, M. (2004). (Eds.), *Handbook of Intercultural Training*. 3rd Edition. London: Sage Publications.
- Martin, M.M., & Andersen, C.M. (1998). The cognitive flexibility scale: three validity studies. *Communication Reports*, 11, 3-9.
- Mezirow, J., & Associates (1990). *Fostering critical reflection in adulthood*. San Francisco: Jossey-Bass.
- Mezirow, J. (1997). Transformative Learning: Theory to Practice. *New Directions for Adult and Continuing Education*, 5, 5-12.

- Moon, J. (2004). Using reflective learning to improve the impact of short courses and workshops. *Journal of Continuing Education in the Health Professions*, 24, 4-11.
- Paige, M. (1993). *Education for the Intercultural Experience*. London: Nicholas Brealey publishing.
- Pekukonis, E., Doyle, O., & Leigh Bliss, D. (2008). Reducing barriers to interprofessional training: promoting interprofessional cultural competence. *Journal of Interprofessional Care*, 22(4), 417-428.
- Popadopoulos, I. (2006). *Transcultural Health and Social Care. Development of culturally competent practitioners*. London: Elsevier.
- Robson, M., & Kitchen, S.S. (2007). Exploring physiotherapy students' experiences of interprofessional collaboration in the clinical setting: a critical incident study. *Journal of Interprofessional Care*, 21(1), 95-109.
- Rutter, L. (2006). Skills support for post-qualifying education: tailoring programmes to meet student needs. *Social Work Education*, 25(3), 279-287.
- Schon, D.A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.
- Smith, E.E., & Kosselyn, S.M. (2007). *Cognitive Psychology: mind and brain*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Sobral, D.T. (2004). What kind of motivation drives medical students' learning quests? *Medical Education*, 38, 90-95.
- Spector, R.E. (2004). *Cultural diversity in health and illness*. 6th edition. New Jersey: Pearson Education/Prentice Hall.
- Stier, J. (2004). Intercultural competencies as a means to manage intercultural interactions in social work. *Journal of Intercultural Communication*, 1-17.
- Van Berkel, H., Schmidt, J.M., & Henk G. (2000). Motivation to commit oneself as a determinant of achievement in problem-based learning. *Higher Education*, 40, 230-241.
- Waite, R., & Calamaro, C.J. (2010). Cultural competence: A systemic challenge to nursing education, knowledge exchange and the knowledge development process. *Perspectives in Psychiatric Care*, 46(1), 74-80.
- Warren, R.G. (1997). Engaging students in Active Learning. *About Campus*, 2(1), 16-20.
- Wight, A. (1995). The critical incident as training tool. In S.M. Fowler & M.G. Mumford (Eds.), *Intercultural Sourcebook: Crosscultural Training Methods*, (pp.127-140). Yarmouth: Intercultural Press.

Documentary Data

Quarterly National Household Survey: Health Status and Health Service utilization. Quarter 3, 2007. Published by Central Statistics Office, Ireland.

Cultural Diversity in the Irish Health Care Sector: Towards the development of policy and practice guidelines for organizations in the health sector. Published by NCCRI and IHSMI. March 2002.

Health Services Intercultural Guide. Responding to the needs of diverse religious communities and cultures in healthcare settings. Published by Health Services Executive. April 2009.